STATE OF MICHIGAN

COURT OF APPEALS

INSTITUTE FOR INNER RESOURCES,

Plaintiff-Appellant,

v

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant-Appellee.

UNPUBLISHED
March 20, 2008

No. 275672
Oakland Circuit Court
LC No. 2006-072399-NF

Before: Talbot, P.J., and Cavanagh, and Zahra, JJ.

PER CURIAM.

Plaintiff appeals as of right from a circuit court order granting defendant's motion for summary disposition under MCR. 2.116(C)(10) in this action to recover no-fault benefits. We reverse. This appeal is being decided without oral argument pursuant to MCR 7.214(E).

Plaintiff provided "neuro-biofeedback" medical treatment to defendant's insured, Justin Rooney, who was injured in a motor vehicle accident. Rooney's no-fault policy provided for coordinated benefits pursuant to MCL 500.3109a. At the time of the accident, Rooney's primary health insurer was Blue Cross/Blue Shield (BCBS). The parties agree that pursuant to the coordination of the coverages, defendant is a secondary insurer and is not required to pay for services covered by the primary insurer. Plaintiff submitted invoices for the neuro-biofeedback treatment to BCBS, which denied coverage. BCBS issued an explanation statement which indicated that the service is a covered benefit only when performed by an M.D. or a D.O. Plaintiff then submitted the treatment invoices to defendant, who also denied coverage. Plaintiff thereafter brought this action for breach of contract and declaratory relief.

The trial court agreed with defendant's argument that it was not responsible for payment because the insured failed to obtain the benefits available through BCBS by complying with BCBS's requirements for payment for the treatment.

On appeal, plaintiff argues that a question of fact exists concerning whether BCBS provides coverage for cognitive therapy.

Summary disposition may be granted under MCR 2.116(C)(10) when "there is no genuine issue of material fact, and the moving party is entitled to judgment . . . as a matter of law." "Affidavits, depositions, admissions, and documentary evidence offered in support or in

opposition to a motion based on subrule . . . (C)(10) shall be considered only to the extent that the content or substance would be admissible as evidence to establish or deny the grounds stated in the motion." MCR 2.116(G)(6). This Court reviews a trial court's decision on a motion for summary disposition de novo. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999).

The no-fault act requires no-fault insurers to offer optional coordination of benefits at reduced premiums when the insured has other health and accident coverage. MCL 500.3109a; *Federal Kemper Ins Co, Inc v Health Ins Administration, Inc,* 424 Mich 537; 383 NW2d 590 (1986), overruled in part on other grounds *Auto Club Ins Ass'n v Frederick & Herrud, Inc,* 443 Mich 358; 505 NW2d 820 (1993). In general, when an insured chooses to coordinate benefits, the health insurer is primarily liable and the no-fault insurer is secondary. *Federal Kemper, supra,* p 551; *Tousignant v Allstate Ins Co,* 444 Mich 301, 308; 506 NW2d 844 (1993). "[A] no-fault insurer is not subject to liability for medical expense that the insured's health care insurer is required, under its contract, to pay for or provide." *Id*., p 303. "[T]he legislative policy that led to the enactment of § 3109a requires an insured who chooses to coordinate no-fault and health coverages to obtain payment and services from the health insurer to the extent of the health coverage available from the health insurer." *Id*., p 307.

Defendant argues that this case is like *Tousignant*, and that it is not responsible for payment of services that would have been covered by BCBS had the insured complied with the requirements of his health insurance plan by obtaining them from an M.D. or a D.O. Defendant argues that the insured's choice to obtain the services outside the limitations imposed by BCBS is akin to the insured's choice in *Tousignant* to obtain services from a non-HAP-affiliated physician. By failing to obtain the services from an M.D. or a D.O., as required by the BCBS policy, the insured failed to obtain services to the extent of the coverage available from BCBS. Relying on BCBS's explanation of benefits, defendant asserts that there is "no question" that the treatment at issue is a covered benefit.

Plaintiff contends that there is a question of fact regarding whether cognitive rehabilitation is a covered benefit under the BCBS policy. In support of its argument, plaintiff presented the article "*TEC Assessment*" from a BCBS website. The article concludes that "cognitive rehabilitation for traumatic brain injury in adults does not meet the TEC criteria." The article also includes a proviso that TEC Assessments are "scientific opinions, provided solely for informational purposes" and "should not be construed to suggest that [BCBS] recommends . . . the payment or non-payment of the technology or technologies evaluated." In further support of its response, plaintiff presented two affidavits of individuals who attended the "Blue Cross Blue Shield Provider Enrichment Program" on August 21, 2006. These affidavits aver that "Blue Cross confirmed that it does not pay for cognitive rehabilitation." Plaintiff argues that this case is more comparable to *Sprague v Farmers Ins Exch*, 251 Mich App 260; 650 NW2d 374 (2002).

We conclude that defendant failed to establish that there was no genuine issue of material fact with respect to its liability for payment. The parties agree that defendant's coverage is secondary to BCBS's coverage, and that it is not required to pay for services covered by BCBS. But unlike in *Tousignant* and *Sprague, supra*, there was a dispute concerning the extent of the coverage available under the BCBS contract. Neither party presented admissible evidence on this point. Defendant relied on the statement in the "Provider Voucher" from BCBS, "THIS SERVICE IS A COVERED BENEFIT ONLY WHEN PERFORMED BY AN MD OR DO."

However, this statement is hearsay when offered to prove the truth of the matter asserted, i.e., that the BCBS contract would cover the service if performed by an M.D. or D.O. physician. Plaintiff submitted affidavits from individuals who averred that they heard a BCBS representative state that coverage is not available. The assertion by the BCBS representative is also hearsay. Inasmuch as defendant's liability depended on a determination of the extent of coverage available from BCBS, admissible evidence was required concerning that coverage.[1] In the absence of admissible evidence showing the coverage that was available under the BCBS policy, defendant was not entitled to summary disposition. See MCR 2.116(G)(6).

Reversed.

/s/ Michael J. Talbot
/s/ Mark J. Cavanagh
/s/ Brian K. Zahra

[1] The parties recognized this need. After defendant filed its reply to plaintiff's response to the motion, defendant filed a motion for an order compelling production of documents, including a certified copy of the BCBS policy, from BCBS; plaintiff concurred with the motion.